MINUTES OF A MEETING OF THE
HEALTH OVERVIEW & SCRUTINY SUB-COMMITTEE
Havering Town Hall
28 April 2015 (7.00 - 9.35 pm)

Present:

Councillors Nic Dodin (Chairman), Dilip Patel (Vice-Chair), Patricia Rumble, Jason Frost and Alex Donald (substituting for Councillor Gillian Ford).

Ian Buckmaster, Director, Healthwatch Havering was also present.

Health officers present:
Caroline O'Donnell and Pippa Ward, North East London NHS Foundation Trust (NELFT)
Steve Russell, Barking, Havering and Redbridge University Hospitals NHS Trust (BHRUT)
Peter Stremes, St Francis Hospice

46 **ANNOUNCEMENTS**

The Chairman gave details of the arrangements in case of fire or other event that may require evacuation of the meeting room.

47 **APOLOGIES FOR ABSENCE AND ANNOUNCEMENT OF SUBSTITUTE MEMBERS**

Apologies for absence were received from Councillor Gillian Ford. Councillor Alex Donald substituted.

Apologies were also received from Dr Susan Milner, Interim Director of Public Health.

48 **DISCLOSURES OF PECUNIARY INTEREST**

There were no disclosures of interest.

49 **MINUTES**

It was agreed that under minute 39 – Havering Mind – Transfer of Mental Health Services that the third sentence of the fifth paragraph should be amended to read 'The CCG had agreed to provide £60,000 of bridge funding to allow Havering MIND clients to continue to access services such as peer support groups'.

The minutes of the meeting of the Sub-Committee held on 19 March 2015 were otherwise agreed as a correct record and signed by the Chairman.

50 BHRUT IMPROVEMENT PLAN

The BHRUT Deputy Chief Executive explained that, following the Trust being placed in special measures in December 2013, an improvement plan was now one year into operation.

In terms of leadership and organisational development, a new Trust Board and Executive team had been in place from November 2014. A Chief Nurse was currently being advertised for. Interviews for the position had been previously held twice but an appointment not made as it was felt important to secure the correct person. The Acting Chief Nurse role was currently being covered by the Trust Director of Midwifery. A Board development programme was in place and structure charts of the Trust could be shared with the Sub-Committee. Work was in progress with the Council to attract more people to BHRUT, including advertising some BHRUT jobs on the Council website. A jobs fair for ED nurses had also recently been held.

The outpatients call centre was now answering 95% of calls compared to 48% previously although it was accepted that more work was needed on this. Phone numbers still needed to be changed on some appointment letters. The call answer times on the Trust switchboard were also still too long on occasions. It was accepted that direct hospital phone numbers should be publicised better and more use made of modern phone technology.

Appointment cancellations had been greatly reduced and in particular there were now only very few instances of multiple appointment cancellations. This had been done by more rigorous application of staff rules concerning booking of leave etc. It was also planned to offer patients more choice of appointment times. Patient pagers had also been introduced meaning patients could wait elsewhere in the hospital should a clinic be running late.

Other initiatives had included a four-day training course for reception staff and the introduction of a new uniform, developed by staff. It was accepted however that a lot of work remained to reduce waiting times for a first outpatient appointment.

On patient experience, 3,000 BHRUT staff had undergone training around the causes of Sepsis and this had reduced outbreaks of the condition at the hospital. New nursing documentation that was more simple and concise had been introduced and a version for short-stay patients was also being developed. Work to make wards more dementia friendly had included the purchase of reminiscence pods and the introductions of menus with food that was easier to eat and did not require cutlery to consume.

It was accepted that more progress was needed with clinical governance and there needed to better learning from serious incidents. The Trust was working with the Good Governance Institute to improve this.

Work with partners on patient flows had included the introduction of a Joint Assessment and Discharge Team as well as the Majors Lite area and having local GPs working in the Urgent Care Centre. There was a new Elders Receiving Unit at Queen's and geriatricians now worked in A&E, allowing some admissions to hospital to be avoided.

Around 93% of A&E patients were now treated within four hours. This had proved challenging to maintain over the winter period and it was accepted that overall targets for the 'four hour rule' were still not being met. This was principally due to there not being sufficient A&E consultants available out of hours. More patients were however now getting hospital beds within four hours of admission.

There remained workforce issues at the Trust although more A&E middle grade doctors had been recruited. The Trust's recruitment process and 'time to hire' measure had been streamlined which it was hoped would aid recruitment. Around 95% of Health Care Assistant posts were now filled with permanent staff, a significant improvement on the previous position. The Deputy Chief Executive accepted however that the Trust needed to do further work to improve its recruitment and related workforce issues.

BHRUT had received announced and unannounced inspections from the Care Quality Commission (CQC) in March 2015. The Trust expected to receive an initial report in the next two weeks with the final CQC report to follow. A quality summit would be held, possibly in June. The outcomes of the report could be that the Trust was taken out of special measures immediately, after a further period of time or continued in special measures. The Trust Deputy Chief Executive felt that coming out of special measures would help the Trust's recruitment but also felt it was important that the improvements the Trust had made were recognised.

The reputation of the Trust in some areas was improving which had helped with recruitment. Other Trusts had come to see how BHRUT worked and better word of mouth helped with e.g. the recent recruitment of 25 more nurses to the ED. It was felt however that the perception of the Trust by junior doctors still required improvement. The consultant recruitment process had been changed and these posts would only now be filled if candidates were thought to be suitable.

It was confirmed that there was a zero tolerance policy at Board level to patients abusing staff. If however the abuse was due to the patient's condition, staff would also be trained in conflict resolution. If abuse was not directly related to a patient's condition, they would be written to by the Trust and could be refused all but emergency treatment.

The Deputy Chief Executive accepted that people were waiting too long to have blood tests and felt that more blood tests should be carried out in the community. Work was in progress with the GP Federation to have more blood tests take place in local facilities. There was no overall target time for a maximum wait for a blood test. It was felt more phlebotomists were needed at the hospital but equally that most blood tests could be carried out away from the hospital site. There was also no alternative site within Queen's Hospital where blood tests could be carried out.

The Urgent Care Centre now saw 110-120 people per day (compared to 80 previously) and it was clarified that the Centre had its own reception desk but not a separate entrance. Registration was needed at the main A&E reception although treatment would be carried out at the Urgent Care Centre and it was accepted that this may need to be communicated better to NHS 111.

The Deputy Chief Executive agreed that there were still delays in delivering discharge medication to patients. Some discharge prescriptions were now written up the day before a patient's discharge was expected and a dispensary operating at ward level was now being piloted.

Members reported that some people had missed appointments at Queen's Hospital as they had been unable to find a parking space. The Deputy Chief Executive understood that the Trust had secured some further off-site parking that would be used for staff, freeing up more parking for patients and visitors. Details of the location of this would be provided.

The Sub-Committee was pleased with the good reputation of Queen's Hospital for stroke and neurology services and that it had not received any negative reports on these areas.

The Deputy Chief Executive agreed that patients should always leave hospital with a discharge summary. More work was needed on these however and he noted reports that patients were often discharged back to care homes with no discharge summaries or other notes to explain what treatment had been received etc.

The Sub-Committee **NOTED** the presentation.

51 NELFT - LONDON ROAD SITE

NELFT officers explained that the Acorn Centre in London Road, Romford had been established as a centre to provide specialist children's services. Services had previously been provided from 13 different locations but were now concentrated at the London Road hub. A virtual tour of the centre had

been produced to assist children who may be nervous about attending and this would be available on the NELFT website.

Services had moved into the new centre in February 2015 and this would include CAMHS initial assessments for new service users. Existing CAMHS service users would continue to be seen at the existing NELFT sites.

Initial feedback regarding the Acorn Centre had been positive with service users liking a receptionist being on duty, it being easier to contact staff and the centre being easier to get to for most people. Murals had been placed on walls at the centre and NELFT was also investigating options to provide further car parking spaces. Feedback from parent groups such as Add-Up and Us Mums had also been mainly positive.

The Acorn Centre had allowed services to be redesigned so that mental and physical health pathways for children could be integrated. A single point of referral was being launched on 1 May whereby appropriate clinicians could be immediately assigned to a case.

Non-clinical areas had been kept to a minimum in the building. Staff had been given mobile Toughbook computers and so did not require permanent desk space. Staff from different areas were learning from each other now that they were working in the same building. There was also a large training area in the new building.

Meetings could now be held on site with therapists and doctors. Joint children's clinics with orthotics and the wheelchair service could also be run from the Acorn Centre.

Toys and dolls houses were available for children visiting the Centre which was also equipped with a gym including hoist equipment for children with disabilities. Test and assessment markers had been permanently inlaid into the floor of consulting areas.

It was conformed that a proposal to establish a charitable enterprise would be taken to the next NELFT executive management team.

There were four full-time paediatricians at the Acorn Centre and Members had held discussions with medical staff during their recent visit to the site. An official opening of the Centre would take place in June to which Councillors would be invited.

It was accepted that some people found the location of the Acorn Centre difficult to get to although services were also still provided from alternative NELFT buildings. Many children were also seen within their school environments. There was only one bus route running along London Road although only a minority of service users went to the Acorn Centre by public transport. Officers would update the Sub-Committee on any problems reported re access or transport.

The Sub-Committee wished NELFT well with the Acorn Centre and it was **AGREED** that an update on progress with the Centre be taken in 6-9 months.

52 SCRUTINY OF BREAST CANCER SERVICES

The BHRUT Deputy Chief Executive explained that the facilities at Victoria Hospital in Romford were no longer fit for purpose and £500,000 had therefore been invested on a new breast care centre of excellence at King George Hospital. This was due to open in stages over the two weeks from 19 May.

Patients had been involved in the design of the new centre which was located in the refurbished Elm ward of King George Hospital. The new centre would have ultrasound, mammograms and consulting rooms on the same site. Offices for specialist radiographers etc would also be located at the centre. Breast screening services would also continue to take place at Harold Wood clinic.

Work was in progress between BHRUT and Transport for London to improve transport links to BHRUT hospitals. The new facility at King George would have better car parking facilities, improved disabled access and longer opening hours (8 am – 8 pm). The Deputy Chief Executive would confirm if enhancements further improving the accuracy of mammogram machines would be available at the new unit. The Trust was also considering the purchase of an OSNA machine which could test the cancerous impact on lymph nodes whilst breast surgery was in progress.

It was **AGREED** to seek to arrange a visit by the Sub-Committee to the new centre, preferably before it opened to the public.

The mobile screening unit would continue to operate and it would be confirmed if this unit now used digital mammography machines. The national standard for the time in which a patient should receive the results of a mammogram would also be confirmed. Additional capacity had been built into the unit at King George to cope with demand and it would be confirmed if the unit was fully staffed.

It was suggested that an existing staff bus link between Queen's and King George Hospitals could be opened for use by patients needing to travel between the two hospitals.

The Sub-Committee **NOTED** the position.

53 HEALTHWATCH HAVERING

1. Urgent Care Survey

A director of Healthwatch Havering explained that a recent survey conducted by Healthwatch in 10 local GP practices had shown a large majority of respondents had indicated they would be interested in using an alternative out of hours care service, even if this was not based at their own surgery. A slightly smaller number (though still a large majority) were content for their patient notes to be shared with an out of hours GP.

2. Dying Matters Week

It was explained that Dying Matters Week was a national event taking place between 18 and 23 May. End of life care was a priority for Healthwatch Havering who felt that people should be allowed to die at home where possible, if that was what they chose. It was felt that it may not always be necessary to admit a dying person to hospital and Healthwatch Havering wished to see every care home operating a gold standard of end of life care.

The Director of PR and Communications at St Francis Hospice explained that Dying Matters Week aimed to get people to talk more openly about dying and make their wishes known. The week's events would be run locally by the Dying Matters Coalition which included the hospice, BHRUT, Havering Clinical Commissioning Group, Healthwatch and local funeral directors and solicitors.

Only 36% of adults had written a will and fewer than this had recorded their wishes around their death, should they be unable to communicate these at the time. The theme of Dying Matters Week – Talk-Plan-Live aimed to get people to discuss these issues more with their loved ones.

Advice would be given during the week on starting conversations concerning death and a themed bus would be in Romford Market on two occasions during this period. Appropriate material would also be displayed at Queen's and King George Hospitals and local solicitors would operate free seminars on will writing and related issues such as a lasting power of attorney.

It was noted that 60% of people would prefer to die at home rather than in hospital and that 20% of hospital beds were occupied by patients who were dying. It was agreed that health professionals also needed to be better at talking about death.

Some 85% of St Francis Hospice patients were seen at home rather than in the hospice itself and many of those who were treated in the hospice were able to return to their homes. The hospice also ran a 24-hour palliative care helpline for primary care staff. It was accepted that the objectives and reasoning behind methods of end of life care should be explained to people

at a time when they were less emotional due to a family member's death being imminent.

The Sub-Committee **NOTED** the updates.

54 URGENT BUSINESS

There was no urgent business raised.

Chairman